Q1. Page 20, 3.6.1.1, J: in Moderate Program requirement, reference to homework assistance, while on page 22, 3.6.1.2, K: Core Services for Moderate, it references tutoring not homework assistance.

R1. Homework assistance can be provided by child care staff, while the tutoring requirement has staff qualifications that must be met. Both are to be provided.

Q2. Section 3.2, page 19. Does the Continuum require a dedicated, full-time Supervisor or can these duties be fulfilled by a staff member that also works on other programs operated by the Agency?

R2. In most cases, a dedicated staff person will be desired. As long as staffing ratios are met, providers may use staff in various functions.

Q3. Section 3.14, page 38. This section references a "Monthly Rate" but section 5.0 references a "Proposed Daily Rate". Which payment structure will be utilized by DHR?

R3. A maximum monthly rate of $4258.80 for out-of home services for one child, with additional add-on rate for out-of-home placements for siblings of $2129.40. For in-home services only, the maximum monthly rate is $2433.60

Q4. Section 3.14, page 38. Our experience has shown that the majority of the cases we serve in the Continuum receive In-Home Services only. As these services are not eligible to be billed to Medicaid, our ability to bill Medicaid for 40% of the total costs of the program is severely restricted and nearly impossible. Can DHR provide guidance as to how Agencies are expected to reach the 40% level if referrals are primarily for In-Home Only services?

R4. Vendors must bill all possible Medicaid Rehab services for in-home service delivery. They may not reach the 40% level.

Q5. Section 4.2.5.1.5, page 41. Should job descriptions be included in the body of the proposal or Included as Attachments (thereby not counting in the page limit maximum)?

R5. Job descriptions may be included as an attachment.

Q6. Section 4.2.5.2, page 41. If an Agency submits a complete copy of their last independent audit, what should be included in the letter from the auditor that is required in this section?

R6. Proposals should include letters from two previous audits.

Q7. Section 5.0, page 44. The last line of this page in italics references a "fixed rate" that is specified in the proposal. We could not locate this. Could DHR provide the specific location of the "fixed rate"?

R7. Refer to R3.

Q8. Section 5.0, page 44. Is there a recommended budget format that DHR would like to see for the program budget?

R8. No.

Q9. **Pg 8, 1.0 Project Overview** Slots in Jefferson, Mobile, Lee, Montgomery, Madison and Cullman represent current Continuum Pilot slots granted to a variety of Providers across the state. Is there current data from each Continuum provider regarding their outcomes during their first contracted year of this pilot project?

a. If so, will that be made public before this RFP must be submitted?
b. Is there comparison data available from all providers?
c. What worked?
d. What didn't?

R9. That information is compiled monthly by SDHR. Each program has had success and areas on which improvements can be made.

Q10. **Page 16, 3.0 Programmatic information** (same section and page)
Family Options:

a. Who will monitor what cases should be referred to Family Options vs. Continuum providers?
b. Can a family receive C of Care services after Family Option services?

R10. a. The services provided by Family Options providers are generally for shorter periods of time. The case worker and ISP team shall make the decision which service is preferable for a specific family.

b. Yes.

Q11. **Page 17 TLP/ILP** When permanency is the goal, under what circumstances would a youth in a C of Care be targeted for these services?

a. Why is this included in the services when most children/youth served here rarely have reunification as their case plan goal?

R11. This service is provided for children that plan to return home or to a relative but need these services during the time that they are in an out-of-home placement.

Q12. **Page 18 Section3, Item 3.1 Staff Qualifications** – Qualifications for supervisor indicate that a person with a Bachelor's Degree meets qualifications if they are supervised "in house" by a Maters level supervisor.

a. Does the person providing the "in house" supervision have to be located in the city where the person is located or can the "in house" supervisor be located in another state?

R12. Supervisors must be located in Alabama.

Q13. **Page 19 3.5 Service Delivery** - The second paragraph says must be accessible to take referrals….etc, again a question regarding the pilots currently operating…

a. How many referrals have been received "after hours" vs. during normal business hours?
b. Have these referrals resulted in immediate placement of children?
c. If so, would Crisis Stabilization services be a possible add on service to C of services?

d. Should emergency shelters available to be used for C of Care clients?

R13. **a. Information is not available.**
b. Information is not available.
c. Crisis stabilization and shelters are not a part of continuum services.
d. Crisis stabilization and shelters are not a part of continuum services.

Q14. **Pg. 19** states "a case is identified as a family not as an individual child", therefore, who determines the management of the family when one member of that family has been identified as the "target" child?
a. Can you have a 2nd party (or other vendor) provide placement for the target child?
b. Who is responsible for the payment of the targeted child?
c. Can the C of C provider provide only for that targeted child and not be responsible for the other siblings?

R14. **Continuum services are for families not just children. A specific child may be identified as the target child, but services are to be delivered to the entire family. Continuum providers may bill for additional siblings, if out-of-home placements are required. Refer to R3.**
a. If they are sub-contracted with the continuum provider. (must be approved by SDHR)
b. Refer to R3.
c. Already answered in above response.

Q15. **Page 20** Cont. Service Delivery
"It is anticipated that treatment through continuum services will last from 9-12 months"…
a. Has this time line held with the pilots across the state?
b. Have extensions been necessary in any of the areas?

R15. **a. and b. Yes, the average continuum case service period is not expected to exceed 9-12 months; however, there have been some occasions when extensions have been granted.**

Q16. **Page 21, Section 3.6 Service Requirements, Item 3.6.1.2 Core Services** for Moderate Programs, a) "Provide medication monitoring and administration" –
Will the provider be expected to provide that service or ensure that it is provided? According to Medicaid section 105 Medication Administration can only be provided by a registered nurse, licensed practical nurse or a physician.

R16. **The core services are being amended to state:**
a. Provide medication administration and monitoring. Medication administration may be provided by the provider if qualified staff to meet Medicaid Chapter 105 requirements is available. Providers are not mandated to provide or pay this service as a part of Core Services.

Q17. **Page 23, Section 3.6 Service Requirements, item 3.6.2.2 Core Services for Basic Programs,** b) Provide a minimum of two hours of basic living skills training daily.
Is this correct since core services for basic residential services require one hour of basic living skills daily?

a. The same question applies for Item 3.6.3.2 Core Services for Mothers and Infants(same page)

R17. Core services for Basic and M&I programs should read 1 hour of basic living skills daily.

Q18. Pg. 36, G. Are the IIHS workers responsible for writing the CFA?

R18. No, the CFA will be completed by the county DHR social worker.

Q19. Sec. 3.10, Pg. 37 AFTERCARE If a child re-enters care for a different reason is the C of C responsible at no additional cost to the Department?

R19. No.

Q20. Sec. 3.9, pg. 37 EJECT/REJECT POLICY

a. 15%..... Has this percentage been reevaluated to determine whether this % should change based on data from previous Continuum program?
b. How is the vendor's responsibility for the child's stability impacted when county DHR chooses to place the child in a placement other than the one recommended by the vendor?
c. Does a subsequent disruption of this placement count against the vendor who provided services but did not determine the placement?
d. c... Is a "validated threat" determined by psychologist, psychiatrist, medical staff, or ,if homicidal, do law enforcements have to be involved?
e. Please define "validated threat"
f. If child is identified AFTER PLACEMENT, as a sexual perpetrator, what is the vendor's expected response?
g. If a child needs services not contracted, such as intensive residential or inpatient substance abuse, would this be a negative discharge from C of Care?
h. If the targeted child perpetrated a non-homicidal assault on a child or adult, what is the vendor's recourse?
i. What is the vendor's response to repeated fire setting which proves to be less than $5000, but remains substantial to the property?

R20.

a. No.
b. Not sure about the question. The ISP team makes all decisions about placement, even through continuums.
c. All placements are through the continuum. We are paying the continuum for permanency, and there may be several moves through the continuum before the goal is attained.
d. A validated threat is one that is taken seriously. It may be evidenced by knowledge that the child has a plan, has been depressed, other observances or outright acts of aggression.
e. See response "d" above.
f. To give care to the child if possible. If treatment has not been received, the case may be suspended until appropriate treatment is received by the child/youth.
g. The case may be SUSPENDED until treatment is received, and then the case continued without showing an unsuccessful discharge.

h. Convene with the ISP team to determine next steps.
i. See response "h" above.

Q21. **Page 37, Sec. 3.10 and 3.11** How long does the Vendor provide supportive services to a child who has been reunited with family?
a. Is aftercare three months or twelve months?
b. **b...** Who is financially responsible for the supportive services after the child has been reunited with family and the case is closed, and past the 3 months after care?
c. How many families served by the current C of C five service areas achieved permanence and remained stable over a 12 month period?
d. What arrays of services have been provided to maintain this stability?
e. Can Family Options be used during this time period?

R21. **a. Aftercare is for three months.**
b. The continuum provider does not provide any service post-aftercare.
c. That information is not available for the RFP purposes.
d. See response "c" above. Each vendor shall describe what he/she plans to provide to promote stability.
e. Only if identified as a need by the ISP team.

Q22. **Page 38, 3.13** Will providers be penalized for families who are non-responsive to tracking attempts?

R22. **If families do not respond, the provider must contact the county DHR office to see if the case has been re-opened.**

Q23. **Page 38, Sec. 3.14** Is there a history from the current programs, regarding the services most likely targeted for Medicaid reimbursement?
a. Are IIH services Medicaid billable?
b. Does the Department want all services billed for Medicaid eligible children or 40% of the monthly rate?
c. Who determines what children are eligible for Medicaid in a family served by the C of C?
d. Is there a primary Medicaid client from one family?
e. If so, does this impact what services will be offered to other family members?
f. How will services be paid for if the children are not in the custody of DHR, and the family is not Medicaid eligible?

R23. **Information is not available.**
a. No.
b. At least 40%, if possible.
c. The county social worker.
d. Any child with Medicaid can be identified as the target child and services billed under that number if the provider is providing services to the entire family.
e. See above.
f. The State will pay for all non-Medicaid services.

Q24. **Page 44 Cost proposal** What is the normal turn around for payments to the C of C providers?

a. May Continuum providers accept referrals for children already in out of home placements?
b. If so, will the Continuum providers begin assuming the cost for that out of home care?
c. If such referrals are acceptable, and the C of Care provider has no cost for the out of home care, are the daily rates the "intensive in-home" daily rate or the higher "out of home rate?
d. What has been the typical monthly rate for this service?
e. What has been the previously contracted rate for IIHS only services?
f. What has been the rate when one or more children have had to be placed in out of home care?

R24. The turn around time for payment is normally within 30 days of receipt of properly submitted invoices.
a. Yes.
b. No, they will bill only the in-home rate.
c. See response "b" above.
d. Refer to R3.
e. Refer to R3.
f. The higher out-of-home rate for one child and an additional 50% rate for each additional child.

Q25. Section 1.6, p. 9, Pre-Proposal Conference: Is the pre-proposal conference mandatory?

R25. Refer to the RFP document. Please adhere to all requirements as specified in the document.

Q26. Are we required to submit a letter of intent?

R26. Refer to the RFP document. Please adhere to all requirements as specified in the document.

Q27. Section 3.0.2, p. 17, Moderate Care: What constitutes a "mental health professional" in the second paragraph on page 17?

R27. A Ph. D. psychologist.

Q28. Section 3.0.2, p. 17, Moderate Care: Would DHR pay for the substance abuse treatment referenced in this section, separate from the daily rates?

R28. Yes.

Q29. Section 3.0.5, p. 18, Therapeutic Foster Care: Does "only children who are in the custody of DHR" refer to the TFC contract? Please clarify.

R29. Only children who are in the custody (or on a boarding home agreement) can be placed in TFC.

Q31. Section 3.1, p. 18, Staff Qualification Requirements, Therapists: Can therapists be certified as ALC and provide therapy?

R31. The requirements are clear in this area.

Q32. Section 3.1, p. 18, Staff Qualification Requirements, Therapists: What is your expectation for the role of the therapist?
a. Is the IHS program required to provide mental health counseling for DSM diagnosis for target child and family members as part of core services?

R32. No, the therapists can provide MHC at an additional cost. The main thrust of the therapist is to work on behavioral goals.

Q33. Section 3.9b, p. 37, Eject/Reject Policy: Please clarify the definition of "validated threat".
a. Section 3.9b, p. 37, Eject/Reject Policy: What if the youth requires intensive residential treatment?

R33. A threat that can be taken seriously, as evidenced by a plan, motive, etc.

Q34. Section 3.11, p. 37, Outcomes: In reference to the last sentence regarding a reduction in contracted slots, would this reduction occur at contract renewal? If not, please outline the process.

R34. Contracts may be changed at anytime during the contract period, as well as at contract renewal.

Q35. Section 5.0, p. 44, Cost Proposal: The Note at the bottom of the page references "a fixed rate". However, no fixed rate is given in the narrative above. Is there a fixed rate proposed? Please clarify the meaning of that term in regards to this RFP.

R35. Refer to R3.

Q36. Section 5.0, p. 44, Cost Proposal: Are psychiatric services to be included in the daily rate that is proposed by the vendor? Please clarify how the psychiatric services will be costed.

R36. No. If needed, an 1878 will be used to recoup cost.

Q37. What is a successful outcome for families referred to the continuum?

R37. A successful discharge means that a child(ren) has achieved his/her permanency goal of return to or remain at home, placed with a relative who will maintain custody of the child, placed with a significant individual to the child (such as a family friend, church member, etc.) that will provide a permanent home for the child or living in their own home independently.